Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ascendant Anesthesia

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-15-0536-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our corrected claim is being denied for being past timely filing, even thought the original claim was accept and partially paid. …I respectfully request a review of this issue as per rules 133.2, 133.200 and 133.10, timely only applies if the claim was rejected as a whole and not partially."

Amount in Dispute: $144.86

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual urges DWC MDR to dismiss Ascendant anesthesia PLLC's request as it is incomplete. No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2014	64445	$144.86	$72.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

Issues

1. Did the requestor submit required documentation to support medical bill?
2. What is the applicable rule to determine reimbursement?
3. Is the requestor entitled to reimbursement?

Findings

1. The carrier's stated, "Rule 133.307(f)(3)(A), "The division may dismiss a request for MFDR if…the division determines that the medical bills in the dispute have not been submitted to the insurance carrier for an appeal, when required." The Division's review will be based off the original denial of the disputed service.

   The carrier denied the disputed service as 16 – "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." Review of the submitted documentation finds;

   a. Medical bill containing disputed code 64445 – 59
   b. Anesthesia record showing Femoral and Popliteal Injection
   c. Screen shot of procedure that is time and date stamped with the claimant's name

   The Division finds the carrier's denial is not supported. The disputed charge will be reviewed per applicable rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (date of service yearly conversion factor). The maximum allowable reimbursement will be calculated as follows; (TDI-DWC Conversion Factor) x (Medicare Conversion Factor) x Facility Price or (69.98 / 35.8228) x 37.02 ($74.04 x 50% reduction based on multiple procedure reduction guidelines) = $72.32
3. The total recommended payment for the services in dispute is $72.32. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $72.32. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $72.32.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $72.32 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 13, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.